CAPITAL REGION OTOLARYNGOLOGY
Head & Neck Group, LLP

Patient Medical History Form

Patients must complete all necessary paperwork prior to being seen by the provider*

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Accompanied by: Mom Dad Grandparent Spouse Caregiver Other _____

Did your doctor refer you today? (Circle one) Yes / No

If yes, name of referring doctor: _____

What is the reason for your visit today? _____

_____

Have you had any related imaging (CT / MRI / X-ray / Ultrasound), or blood work done recently? Where? _____

_____

Did you receive the flu shot this flu season (between November and March)? (Circle one) Yes / No

If Yes, when? Month: _____ Day: _____ Year: _____ **if not sure of exact date please approximate*

Medical History: Current Medical Problems you are being treated for:

( ) Anxiety	( ) Depression	( ) HIV
( ) Arthritis	( ) Diabetes	( ) Kidney Disease
( ) Asthma	( ) Heart Disease	( ) Reflux/GERD
( ) Bleeding Disorder	( ) Hepatitis	( ) Seizures
( ) Cancer (list type) _____	( ) High Blood Pressure	( ) Stroke
( ) COPD	( ) High Cholesterol	( ) Thyroid Disease
( ) Emphysema	( ) Other _____	

_____

Surgical History: Please list all previous surgeries:

Surgery	Date of Surgery	Facility

In-Patient Hospitalizations: _____

_____

Medications: Please list all medications you are taking including **strength**, **directions,** and **reason**

_____

_____

_____

_____

_____

Allergies: Please list all allergies to medications or other substances and ***TYPE OF REACTION***

Medication/Substance	Reaction

Family Medical History Please circle all that apply

No current problems	Father	Mother	Brother	Sister	Son	Daughter
Asthma	Father	Mother	Brother	Sister	Son	Daughter
Cancer	Father	Mother	Brother	Sister	Son	Daughter
Diabetes	Father	Mother	Brother	Sister	Son	Daughter
Hearing Loss	Father	Mother	Brother	Sister	Son	Daughter
Heart Disease	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure	Father	Mother	Brother	Sister	Son	Daughter
Thyroid Disease	Father	Mother	Brother	Sister	Son	Daughter
Unknown	Father	Mother	Brother	Sister	Son	Daughter

Other: _____

_____

Social History

Marital Status: Never Married Married Legally Separated Divorced Widowed

Tobacco:

1. Do you **smoke** Tobacco? Yes / No

If **YES**, how many packs per day? _____

How long have you smoked? _____

If **NO**, have you ever smoked in the past? Yes / No

When did you quit? _____

2. Do you use **smokeless** tobacco? Yes / No

How many times per day? _____

3. Are you exposed to second hand smoke? Yes / No

Alcohol: Do you drink alcohol? Yes / No

If yes, please choose one:

Rarely Occasionally Socially Daily- How much per day?_____

Caffeine: Please indicate quantity consumed per day

Coffee _____ cups per day Tea _____ cups per day Soda _____ oz per day

REVIEW of SYSTEMS: Do you currently have any of the following?

Constitutional
( ) Weight loss
( ) Weight gain
( ) Daytime sleepiness

Eyes
( ) Abnormal vision

Ears
( ) Ear pain- L / R
( ) Ear pressure- L / R
( ) Ringing- L / R

Nose/Sinus
( ) Runny nose
( ) Nasal congestion

Mouth/Throat
( ) Trouble swallowing
( ) Chronic cough

Cardiovascular
( ) Chest Pain
( ) Palpitations

Respiratory
( ) Shortness of breath
( ) Snoring

Gastrointestinal
( ) Nausea
( ) Vomiting
( ) Constipation
( ) Diarrhea
( ) Abdominal pain

Urinary
( ) Trouble urinating

Musculoskeletal
( ) Muscle pain
( ) Joint pain

Skin
( ) Skin problems

Hematologic/Lymphatic
( ) Bruising

Neurology
( ) Headaches
( ) Dizziness

Psych
( ) Depression
( ) Insomnia

Endocrine
( ) Excessive thirst

Patient/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____